IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

CASE NO. 07-61329 CIV-MARRA

UNITED STATES OF AMERICA,

Plaintiff,

vs.

CHRISTI R. SULZBACH,

Defendant.
_____/

MAGISTRATE JUDGE JOHNSON

COMPLAINT

For its Complaint, the United States of America alleges as follows:

I. NATURE OF ACTION

1. The United States brings this action to recover statutory damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729-33.

2. During most of the period relevant to this Complaint, Defendant Christi R. Sulzbach was the Associate General Counsel and Corporate Integrity Program Director at Tenet Healthcare Corporation (Tenet). As such, she was personally responsible for investigating any alleged violations by Tenet employees of any federal program legal requirements, and for reporting to the Government the existence and status of any such investigation. In 1999, she became Tenet's General Counsel.

3. In early 1997, Defendant Sulzbach learned that a Tenet-owned hospital in Florida, North Ridge Medical Center (North Ridge), was violating the Stark Statute, 42 U.S.C. § 1395nn, by illegally billing Medicare for referrals from certain employee physicians whose contracts violated the Stark Statute. She directed Tenet's outside counsel to investigate, and outside counsel confirmed that a number of the physician employment contracts were illegal. Defendant Sulzbach nevertheless signed and provided to the Government declarations in late June 1997 and June 1998 that falsely stated that to the best of her knowledge and belief, Tenet was in material compliance with all federal program legal requirements.

4. Defendant Sulzbach's false declarations allowed Tenet to bill Medicare for millions of dollars in claims that it was not legally entitled to receive under the Stark Statute. Her false declarations also obstructed the Government's discovery and recoupment of millions of dollars of improper payments that Tenet had already received.

5. In May 1997, a Tenet employee named Sal Barbera filed a *qui tam* action against Tenet that alleged that the physician employment contracts at issue were illegal. The Government investigated, litigated, and eventually settled these claims with Tenet for $22.5 million. Throughout this process, Tenet's legal team, under Defendant Sulzbach's personal direction, consistently

denied that the physician employment arrangements at issue violated the Stark Statute.

6. In 2006, Tenet entered into a settlement with the Government to resolve a variety of claims that it had defrauded and overcharged the Medicare program. Among other things, Tenet agreed to pay the Government $920 million, and to produce to the Government a number of documents that had previously been withheld as privileged, including a small number of documents related to the Barbera *qui tam* case. These documents established that Defendant Sulzbach knew that her declarations were false at the time she made them. This action seeks damages and penalties against Defendant Sulzbach for her role in personally facilitating the false claims submitted by Tenet.

II. JURISDICTION

7. The Court has subject matter jurisdiction to entertain this action under 28 U.S.C. §§ 1331 and 1345. The Court may exercise personal jurisdiction over the defendant pursuant to 31 U.S.C. § 3732(a).

III. VENUE

8. Venue is proper in the Southern District of Florida, under 28 U.S.C. § 1391(b) and 31 U.S.C. § 3732, because the defendant transacted business in this district and committed acts within this district that violated 31 U.S.C. § 3729, and because

a substantial part of the events at issue in this case occurred in this district.

IV. PARTIES

9. The United States brings this action on behalf of the Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration), and the Medicare Program.

10. Defendant Sulzbach is a resident of Santa Barbara, California. During the relevant time period, she transacted business in Florida in her capacity as Tenet's counsel and Corporate Integrity Program Director.

V. THE LAW

A. The False Claims Act

11. The False Claims Act provides, in pertinent part, that:

> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government . . . a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or or statement to get a false or fraudulent claim paid or approved by the Government; . . . or (7) knowingly makes, uses or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
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> * * *
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person. . . .

> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729.

B. <u>The Stark Statute</u>

12. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare Program, to pay for the costs of certain healthcare services for elderly and disabled Americans. Part A of the Medicare Program authorizes payment for institutional care, including hospital, skilled nursing facility and home health care. *See* 42 U.S.C. §§ 1395c-1395i-4. Most hospitals, including North Ridge, derive a substantial portion of their revenue from the Medicare Program.

13. HHS is responsible for the administration and supervision of the Medicare Program. CMS, an agency of HHS, is directly responsible for the administration of the Medicare Program.

14. A section of the Social Security Act, 42 U.S.C. § 1395nn (commonly known as the "Stark Statute") prohibits a hospital (or other entity providing healthcare items or services) from submitting Medicare claims for payment for certain designated health services based on patient referrals from

physicians having an improper "financial relationship" (as defined in the statute) with the hospital. The statute states that no Medicare payment may be made for designated health services provided in violation of the statute. 42 U.S.C. § 1395nn(g)(1).

15. The regulations implementing 42 U.S.C. § 1395nn require that any entity collecting payment for a healthcare service "performed under a prohibited referral must refund all collected amounts on a timely basis." 42 C.F.R. § 411.353.

16. In enacting the Stark Statute, Congress found that improper financial relationships between physicians and entities to whom they refer patients can compromise the physicians' professional judgment as to whether an item or service is medically necessary, safe, effective, and of good quality. Congress relied upon various academic studies consistently showing that physicians who had financial relationships with medical service providers used more of those providers' services than similarly situated physicians who did not have such relationships. The statute was designed to reduce the loss suffered by the Medicare Program due to such increased questionable utilization of services.

17. Congress enacted the Stark Statute in two parts, commonly known as Stark I and Stark II. Enacted in 1989, Stark I applied to referrals of Medicare patients for clinical laboratory

services made on or after January 1, 1992, by physicians with a prohibited financial relationship with the clinical lab provider. *See* Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, § 6204.

18. In 1993, Congress extended the Stark Statute (Stark II) to referrals for ten additional designated health services. *See* Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, § 13562, Social Security Act Amendments of 1994, P.L. 103-432, § 152.

19. As of January 1, 1995, Stark II applied to patient referrals by physicians with a prohibited financial relationship for the following ten additional "designated health services": (1) inpatient and outpatient hospital services; (2) physical therapy; (3) occupational therapy; (4) radiology; (5) radiation therapy (services and supplies); (6) durable medical equipment and supplies; (7) parenteral and enteral nutrients, equipment and supplies; (8) prosthetics, orthotics and prosthetic devices and supplies; (9) outpatient prescription drugs; and (10) home health services. *See* 42 U.S.C. § 1395nn(h)(6).

20. In pertinent part, the Stark Statute provides:

> (a) Prohibition of certain referrals.
>
> (1) In general.
>
> Except as provided in subsection (b), if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then --

> (A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this title, and
>
> (B) the entity may not present or cause to be presented a claim under this title or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).

42 U.S.C. § 1395nn (emphasis added).

21. The Stark Statute broadly defines prohibited financial relationships to include any "compensation" paid directly or indirectly to a referring physician. The statute's exceptions then identify specific relationships that will not trigger its referral and billing prohibitions.

22. One such relationship is an employment relationship between a hospital and a physician, but the relationship will only qualify for the exception if the amount of the remuneration paid to the doctor (1) is consistent with the fair market value of the doctor's services, (2) would be commercially reasonable even if no referrals were made to the hospital, and (3) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician.

VI. TENET'S HISTORY

23. Tenet was formed in 1995 in a merger between National Medical Enterprises, Inc. (NME) and American Medical Holdings, Inc. (AMH). Defendant Sulzbach was in-house counsel at NME prior to the merger.

24. In June 1994, NME entered into an agreement with the Government to settle allegations that NME had engaged in a wide range of illegal conduct, including (a) providing illegal remuneration to referral sources in exchange for referrals, (b) billing the Government for medically unnecessary services, for false diagnoses, and for services that were not in fact rendered, (c) double billing, and (d) denying patients necessary services. As part of this settlement, NME agreed to pay a then-record $379 million (including a $33 million criminal fine) and to enter into a five-year "Corporate Integrity Agreement" that required NME to implement a corporate integrity program. Defendant Sulzbach personally signed the civil settlement agreement and the Corporate Integrity Agreement on behalf of NME.

25. Under the terms of its Corporate Integrity Agreement, NME agreed, among other things:

(a) to obtain formal approval of outside counsel for contracts involving payments to physicians, to preserve opinions of outside counsel approving such contracts in

NME's contract files, and to make evidence of such approval available to HHS upon request;

(b) to establish a Corporate Integrity Program "to ensure, to the extent reasonably possible, that NME and each of its directors, officers, employees and contractors maintain the business integrity required of a participant in federally-funded health care programs, and that NME's delivery of medical care is in compliance with all laws and regulations applicable to such programs and with the terms of this Agreement";

(c) to establish a Corporate Integrity Program Management Committee that included the Associate General Counsel with responsibility for compliance;

(d) to provide to HHS annual Compliance Reports setting forth the company's compliance with the Corporate Integrity Agreement and with federal program legal requirements, and including, among other things, (i) certifications stating that the company "is either in compliance or noncompliance with . . . federal program legal requirements," and (ii) "[t]he status of any ongoing investigation of . . . NME's compliance with federal program legal requirements;"

(e) to allow the Government to review and inspect all books and records upon which the company's determination of

compliance or noncompliance was based, and to provide such additional information and documentation as might be required by the Government to verify the representations in the annual report, compliance with the Corporate Integrity Agreement, and with all federal program legal requirements;

(f) to report to HHS any credible evidence of misconduct that management had reasonable grounds, after appropriate inquiry, to believe constituted a material violation of the civil law or rules and regulations governing federally funded health care programs;

(g) to investigate any report of misconduct by NME employees that came to its attention, to notify the U.S. Department of Justice and HHS of the outcome of the investigation, and to include a summary of the status of each such investigation to HHS in the company's annual Compliance Report; and

(h) to take appropriate corrective action of problems identified in its internal investigations, including making prompt restitution to the Government of any damages to the extent that NME was legally responsible for such damages.

26. After NME merged with AMH to form Tenet, the merged company continued to operate under the terms of the NME Corporate

Integrity Agreement until June 1999, when the agreement expired. Additionally, Defendant Sulzbach became Tenet's Associate General Counsel and Corporate Integrity Program Director. As such, she was primarily responsible for ensuring Tenet's compliance with the Corporate Integrity Agreement.

VII. TENET'S ILLEGAL EMPLOYMENT CONTRACTS

27. Between April 5, 1993, and August 8, 1994, North Ridge entered into employment contracts with twelve physicians (Drs. Michael Angelillo, Martin Coleman, Mark Copen, Michael Dolchin, Leonard Erdman, David Gozansky, Harold Mellin, Howard Perer, Alan Schwartz, Richard Shapiro, John Shook, and Alan Yesner) under which the physicians were paid well above fair market value.

28. Before North Ridge hired the twelve physicians, it obtained data relating to their practice levels, office expenses and other related information. North Ridge employees analyzed this data to project estimated office revenues, physician compensation, and expenses for the employee physician practice.

29. Each of the financial analyses indicated that the practices themselves would suffer significant annual losses at the compensation level projected for the employee physicians.

30. Most of the financial analyses also showed the projected revenues that North Ridge would receive from clinical laboratory outpatient referrals from the physicians once they were hired. The statements showed that the anticipated

laboratory referrals would greatly reduce or even eliminate the projected losses from the physicians' practices.

31. North Ridge agreed to pay each of the twelve physicians far more than his previous salary.

32. As discussed below, Defendant Sulzbach directed Tenet's outside counsel, the law firm of McDermott, Will & Emery, to analyze the employment contracts of a number of physicians at North Ridge, including the twelve physicians whose contracts are at issue in this case. On May 27, 1997, the firm produced a report for Tenet ("the May 1997 McDermott Report") discussing its findings. Among the findings summarized in the "executive summary" at the beginning of the report were:

(A) "Almost half of the physician arrangements reviewed for North Ridge Medical Center reflected that the physician's compensation was tied to the volume or value of laboratory referrals such physician made to the hospital."

(B) "A number of the physicians have been compensated and continue to be compensated in excess of the fair market value for services rendered. . . . Specifically, over half of the arrangements reviewed for North Ridge Medical Center indicate that the physicians are being compensated more than the net revenue generated by the group."

(C) "[A]lmost all the arrangements reviewed for North Ridge Medical Center do not appear to be commercially reasonable without considering the referrals to the hospital."

33. On June 23, 1997, McDermott, Will & Emery produced a revised version of the May 1997 McDermott Report. This version ("the June 1997 McDermott Report") reached the same general conclusions as the May 1997 version, and repeated verbatim the passages quoted in the preceding paragraph.

(A) Drs. Gozansky, Dolchin and Copen

34. Drs. David Gozansky, Michael Dolchin and Mark Copen entered into ten-year employment contracts with North Ridge in September 1993. Under these contracts, each doctor received a base salary of $275,000 per year, a signing bonus of $45,000, and the opportunity to earn additional incentive bonuses.

35. Drs. Gozansky, Dolchin, and Copen practiced as a group before North Ridge hired them. According to their corporate federal income tax returns, each physician reported wages of between $155,000 and $160,000 in the year prior to his employment by North Ridge. Thus, not counting bonuses, the base salaries that these doctors received from North Ridge exceeded their previous wages by over 71%.

36. On August 30, 1993, shortly before hiring Drs. Gozansky, Dolchin and Copen, North Ridge prepared a two-page

financial analysis of their projected revenues and expenses for their first year of North Ridge employment. This document showed that North Ridge would lose an estimated $380,223 on the physicians' practice if their laboratory referrals to North Ridge were not factored in. However, the analysis also showed that the hospital expected the three physicians to refer $272,310 worth of laboratory referrals to it per year, reducing the hospital's projected loss in the first year to roughly $108,000. Projecting alternative volumes of growth of 3 percent, 5 percent and 7 percent in the first year of employment, the financial analysis concluded that North Ridge would suffer an annual loss on the practices of these three doctors of roughly $40,000 to $70,000.

37. In the year before they signed their employment contracts, Drs. Gozansky and Copen did not refer any of their patients to North Ridge for inpatient stays, and only 3% of Dr. Dolchin's inpatient referrals were to North Ridge. By contrast, in their first year of employment at North Ridge, of those patients referred for hospital inpatient stays, Dr. Copen referred 73% of his patients to North Ridge; Dr. Dolchin referred 66% of his patients to North Ridge; and Dr. Gozansky referred 42% of his patients to North Ridge. By 1995, Dr. Copen was referring 80% of the patients he referred for inpatient stays to North Ridge, Dr. Dolchin was referring 78% and Dr. Gozansky was referring 70%.

38. The May 1997 McDermott Report included a detailed analysis of North Ridge's contract with Dr. Dolchin. The report stated that Dr. Dolchin's compensation arrangement "appears to be problematic because it appears Dr. Dolchin's compensation takes into account the volume and value of referrals to North Ridge." After analyzing the financial performance of Dr. Dolchin's practice, the report also stated, "These statistics raise fair market value concerns and do not appear to be commercially reasonable without considering the referrals to the Hospital." The report then stated that the same analysis applied to North Ridge's contracts with Drs. Gozansky and Copen.

39. The June 1997 McDermott Report contained the same analysis and conclusions as the May 1997 Report concerning the practices of Drs. Gozansky, Dolchin, and Copen, and it repeated verbatim the language quoted in the preceding paragraph.

(B) Dr. Yesner

40. Doctor Alan Yesner entered into a ten-year employment contract with North Ridge in November 1993. Under this contract, Dr. Yesner received a base salary of $275,000 per year, a $25,000 signing bonus, and the opportunity to earn additional incentive bonuses. In August 1995, North Ridge amended this contract to increase Dr. Yesner's base salary to $283,000.

41. Dr. Yesner engaged in solo practice before he was hired by North Ridge. Upon information and belief, his wages from his

practice in the year prior to his employment by North Ridge were $162,991. Thus, not counting bonuses, the base salary that Dr. Yesner received from North Ridge exceeded his previous wages by over 68%.

42. Before North Ridge hired Dr. Yesner, it prepared a one-page financial analysis of his projected revenues and expenses for his first year of North Ridge employment. This September 16, 1993, document showed that North Ridge would lose an estimated $60,078 on Dr. Yesner's practice if his laboratory referrals to the hospital were not factored in. However, the analysis also showed that the hospital expected Dr. Yesner to refer $64,991 worth of laboratory referrals to it per year, resulting in an anticipated annual profit of nearly $5,000. The pro forma contained a footnote that stated, in part, "The 'baseline' salary shown was designed to max-out at break-even, when NRMC lab work is included."

43. From October 1992 through September 1993, before signing his North Ridge employment contract, Dr. Yesner referred 93% of those patients he referred for hospital inpatient stays to a nearby hospital and only 5% to North Ridge. By 1997, he referred 81% of those patients he referred for hospital inpatient stays to North Ridge.

44. The May 1997 McDermott Report contained a detailed analysis of North Ridge's contract with Dr. Yesner. On the issue

of whether Dr. Yesner's salary was determined in a manner that took into account the volume or value of his referrals, the May 1997 McDermott Report stated, "According to the materials contained in the file, it appears that Dr. Yesner's salary was directly tied to the Hospital receiving his laboratory revenues." It also stated, "This compensation arrangement appears to be problematic because it appears Dr. Yesner's compensation takes into account the volume and value of referrals to North Ridge."

45. On the issue of whether Dr. Yesner's compensation was commercially reasonable and reflected the fair market value of his services, the May 1997 McDermott Report analyzed the costs and revenues associated with Dr. Yesner and concluded that Dr. Yesner's compensation was "problematic because it does not appear to be commercially reasonable if no referrals were made to North Ridge. Additionally, there are concerns about the fair market value of his compensation."

46. The June 1997 McDermott Report contained the same analysis and conclusions as the May 1997 Report concerning Dr. Yesner's practice, and it repeated verbatim the language quoted in the preceding two paragraphs.

(C) Drs. Mellin and Schwartz

47. Drs. Harold Mellin and Alan Schwartz entered into ten-year employment contracts with North Ridge in February 1994. Under these contracts, each doctor received a base salary of

$225,000 per year, plus an annual cost of living increase, plus the opportunity to earn additional incentive bonuses.

48. According to their corporate federal income tax returns, Drs. Mellin and Schwartz reported wages of $125,000 and $122,000, respectively, in the year prior to their employment by North Ridge. Thus, not counting bonuses, the base salaries that they received from North Ridge exceeded their previous wages by 80% and 84%, respectively.

49. Before North Ridge hired Drs. Mellin and Schwartz, it prepared a one-page analysis of their projected revenues and expenses for their first year of North Ridge employment. This December 17, 1993, document showed that North Ridge would lose an estimated $353,514 on Drs. Mellin and Schwartz' practice if their laboratory referrals to North Ridge were not factored in. However, the analysis also showed that the hospital expected these physicians to refer $214,037 worth of laboratory referrals to it per year, reducing the hospital's projected loss to approximately $140,000.

50. In 1993, Drs. Mellin and Schwartz referred between 95% and 96% of those patients referred for inpatient stays to a nearby hospital and less than 5% to North Ridge. By 1995, Dr. Schwartz referred 88% of those patients requiring inpatient stays to North Ridge, and Dr. Mellin referred 95%.

51. The May 1997 McDermott Report contained a detailed analysis of North Ridge's contracts with Drs. Mellin and Schwartz. On the issue of whether their salaries were determined in a manner that took into account the volume or value of their referrals, the May 1997 McDermott Report stated, "According to the materials contained in the file, it appears Drs. Mellin and Schwartzs' [sic] salaries were directly tied to the hospital receiving laboratory revenues." It also stated, "This compensation arrangement appears to be problematic because it appears Drs. Mellin's and Schwartzs' [sic] compensations take into account the volume and value of referrals to North Ridge."

52. On the issue of whether the compensation of Drs. Mellin and Schwartz were commercially reasonable and reflected the fair market value of their services, the May 1997 McDermott Report analyzed the costs and revenues associated with their practice and concluded, "These statistics raise fair market value concerns in that the physicians are being compensated more than [their] net revenues." The report also stated that "it appears that the arrangement may not be commercially reasonable if the laboratory referrals are not taken into account when calculating the physicians' compensations."

53. The June 1997 McDermott Report contained the same analysis and conclusions as the May 1997 Report concerning the

practices of Drs. Mellin and Schwartz, and it repeated verbatim the language quoted in the preceding two paragraphs.

(D) Drs. Shapiro and Angelillo

54. Drs. Richard Shapiro and Michael Angelillo entered into ten-year employment contracts with North Ridge in April 1993. Under these contracts, each doctor received a base salary of $185,000 per year, plus an annual cost of living increase of 5%, plus a payment of $20,000 per year, plus the opportunity to earn additional incentive bonuses.

55. Upon information and belief, Dr. Shapiro's 1992 wages were $117,028 and Dr. Angelillo's 1992 wages were $109,697. Thus, not counting incentive bonuses or cost of living increases, the base compensation that Drs. Shapiro and Angelillo received from North Ridge exceeded their previous wages by 75% and 86%, respectively.

56. Before North Ridge hired Drs. Shapiro and Angelillo, it prepared an analysis of their projected revenues and expenses for their first and second year of North Ridge employment. The analysis, which was undated, showed that North Ridge would lose an estimated $381,359 and $332,864 on Drs. Shapiro and Angelillo's practice in their first and second years of employment if their laboratory referrals to North Ridge were not factored in. However, the analysis also showed that the hospital expected these physicians to refer $233,587 worth of laboratory

referrals to it in the first year and $248,375 in the second year, reducing the hospital's projected losses to roughly $148,000 in the first year and $85,000 in the second year.

57. The incentive bonuses of Drs. Shapiro and Angelillo remained a source of controversy with North Ridge throughout their years of employment. When it was concluded in 1994 that their incentive bonuses required a number of office visits which "will never be achieved," North Ridge agreed to amend the employment contract to lower the number of office visits required for them to earn their bonuses.

58. From April 1992 through March 1993, prior to employment by North Ridge, Drs. Shapiro and Angelillo referred their patients predominantly to two hospitals near their offices. In that period of time, Dr. Shapiro referred 3% of the patients requiring inpatient stays to North Ridge, and Dr. Angelillo referred none of his patients for inpatient stays to North Ridge. Subsequent to their employment at North Ridge, they referred between 21% and 31% of the patients they admitted for inpatient hospital stays to North Ridge.

59. The May 1997 McDermott Report contained a detailed analysis of North Ridge's contracts with Drs. Shapiro and Angelillo. On the issue of whether their salaries were determined in a manner that took into account the volume or value of their referrals, the May 1997 McDermott Report stated,

"According to the materials contained in the file, it appears that Dr. Angelillo's and Dr. Shapiro's salaries were directly tied to the hospital receiving its laboratory revenues." It also stated, "This compensation arrangement appears to be problematic because it appears Dr. Angelillo's and Dr. Shapiro's compensations take into account the volume and value of referrals to North Ridge."

60. On the issue of whether the compensation of Drs. Shapiro and Angelillo was commercially reasonable and reflected the fair market value of their services, the May 1997 McDermott Report analyzed the costs and revenues associated with their practice and concluded, "This compensation is problematic because it does not appear to be commercially reasonable if no referrals were made to North Ridge. Additionally, there are concerns about the fair market value of the physicians' compensations."

61. The June 1997 McDermott Report contained the same analysis and conclusions as the May 1997 Report concerning the practices of Drs. Shapiro and Angelillo, and it repeated verbatim the language quoted in the preceding two paragraphs.

(E) Drs. Shook and Erdman

62. Drs. John Shook and Leonard Erdman entered into five-year employment contracts with North Ridge in or about August 1994. Dr. Erdman's contract provided that he would receive a base annual salary of $140,000, plus the opportunity to earn

incentive bonuses, but would not work more than 155 days per year. Dr. Shook's contract provided for a base annual salary of approximately $195,000, plus the opportunity to earn incentive bonuses.

63. Upon information and belief, Drs. Shook and Erdman earned wages of approximately $104,000 and $81,000, respectively, before they were hired by North Ridge. Thus, not counting incentive bonuses, the base salaries that they received from North Ridge exceeded their previous wages by more than 87% and 72%, respectively.

64. Before North Ridge hired Drs. Erdman and Shook, it prepared a one-page analysis of their projected revenues and expenses for their first year of North Ridge employment. The analysis, which was dated March 24, 1994, showed that North Ridge would lose approximately $95,000 on their practice in their first year of employment.

65. Before they were hired by North Ridge in 1994, Drs. Erdman and Shook referred virtually no patients to North Ridge. By 1996, Dr. Erdman referred 79% of his patients admitted to a hospital for inpatient stays to North Ridge, and Dr. Shook referred 63% of his patients admitted to a hospital for inpatient stays to North Ridge.

66. The May 1997 McDermott Report contained a detailed analysis of North Ridge's contracts with Drs. Shook and Erdman.

On the issue of whether their salaries were determined in a manner that took into account the volume or value of their referrals, the May 1997 McDermott Report quoted an August 25, 1995 e-mail from one Tenet executive to another, which stated, "as you may know, we are negotiating for employment with them [referring to Drs. Shook and Erdman]. I need. . . . their most recent 12 month collections, showing laboratory separate from everything else."

67. On the issue of whether the compensation of Drs. Shook and Erdman were commercially reasonable and reflected the fair market value of their services, the May 1997 McDermott Report analyzed the costs and revenues associated with their group practice when they were hired and concluded, "These statistics appear to raise fair market value concerns in that the physicians' salaries doubled, yet there was no expectation for an increase in visits for a number of the physicians, and there was a minimal increase in net revenue." Analyzing more recent financial data concerning the doctors' practices, the report stated, "These statistics raise fair market value concerns in that the physicians are being compensated more than the net revenues."

68. The June 1997 McDermott Report contained the same analysis and conclusions as the May 1997 Report concerning the

practices of Drs. Shook and Erdman, and it repeated verbatim the language quoted in the preceding two paragraphs.

(F) Dr. Perer

69. Dr. Howard Perer entered into a five-year employment contract with North Ridge on October 25, 1993. This contract provided that he would receive a base annual salary of $225,000, plus an annual cost of living increase, plus a $10,000 per year "license fee," plus the opportunity to earn incentive bonuses.

70. Upon information and belief, Dr. Perer's wages in 1992 were $94,000. Thus, not counting incentive bonuses or cost of living increases, Dr. Perer's base compensation at North Ridge (including the license fee) was exactly two and a half times his previous wages.

71. Before North Ridge hired Dr. Perer, it prepared a one-page analysis of his projected revenues and expenses for his first year of North Ridge employment. The analysis, which was dated August 19, 1993, showed that North Ridge would lose an estimated $119,320 on Dr. Perer's practice if his laboratory referrals to North Ridge were not factored in. However, the analysis also showed that the hospital expected Dr. Perer to refer $90,770 worth of laboratory referrals to it per year, reducing the hospital's projected loss to approximately $29,000.

72. From October 1992 through September 1993, Dr. Perer referred approximately 75% of the patients he admitted to a

hospital for inpatient stays to North Ridge. After employment, he referred almost all of his patients admitted to a hospital for inpatient stays to North Ridge.

73. The May 1997 McDermott Report analyzed the revenues and costs associated with Dr. Perer's practice, and concluded, "These statistics raise fair market value concerns and do not appear to be commercially reasonable without considering the referrals to the Hospital."

74. The June 1997 McDermott Report contained the same analysis and conclusions as the May 1997 Report concerning Dr. Perer's practice, and it repeated verbatim the language quoted in the preceding paragraph.

(G) Dr. Coleman

75. Dr. Martin Coleman entered into a five-year employment contract with North Ridge on October 25, 1993. Dr. Coleman's contract provided that he would receive a base annual salary of $275,000, plus an annual cost of living increase, plus the opportunity to earn incentive bonuses. The contract also provided that Dr. Coleman could suspend all payments on a $56,952 debt that he owed North Ridge at the time of the agreement, and that the debt would be forgiven completely over the course of the contract.

76. Upon information and belief, Dr. Coleman's 1992 wages were $214,000. Thus, not counting incentive bonuses, cost of

living increases, or the forgiveness of his loan, Dr. Coleman's base salary at North Ridge exceeded his previous wages by more than 28%.

77. Before North Ridge hired Dr. Coleman, it prepared a one-page analysis of his projected revenues and expenses for his first year of North Ridge employment. This August 19, 1993, document showed that North Ridge would lose an estimated $145,595 on Dr. Coleman's practice if his laboratory referrals to North Ridge were not factored in. However, the analysis also showed that the hospital expected Dr. Coleman to refer $122,539 worth of laboratory referrals to it per year, reducing the hospital's projected loss to roughly $23,000.

78. From October 1992, through September 1993, Dr. Coleman referred approximately 75% of the patients he admitted to a hospital for inpatient stays to North Ridge. After employment, he referred almost all of his patients admitted to a hospital for inpatient stays to North Ridge.

79. On the issue of whether Dr. Coleman's compensation was determined in a manner that took into account the volume or value of his referrals, the May 1997 McDermott Report stated, "According to the proforma, dated August 19, 1993, it appears Dr. Coleman's salary was directly tied to the Hospital receiving his laboratory revenue." It also stated, "This compensation arrangement appears to be problematic because it appears Dr.

Coleman's compensation takes into account the volume and value of referrals to North Ridge."

80. On the issue of whether Dr. Coleman's compensation was commercially reasonable and reflected the fair market value of his services, the May 1997 McDermott Report analyzed the costs and revenues associated with his practice and concluded, "These statistics raise fair market value concerns and do not appear to be commercially reasonable without considering the referrals to the Hospital."

81. The June 1997 McDermott Report contained the same analysis and conclusions as the May 1997 Report concerning Dr. Coleman's practice, and it repeated verbatim the language quoted in the preceding two paragraphs.

VIII. DEFENDANT SULZBACH'S MISCONDUCT

82. In February 1997, a Tenet executive named Tony Bennett wrote a memorandum ("the Bennett Memo") to Jeffrey Heinemann, his boss, expressing concern that certain physician contracts at North Ridge violated the Stark Statute.

83. The Bennett Memo explained that under the Stark Statute, a physician employment relationship is only permissible if it is "consistent with fair market value, does not take into account the volume of referrals, and is for payment that would be commercially reasonable if there were no referrals."

84. The Bennett Memo explained that Mr. Bennett had reviewed the files of certain North Ridge physicians and determined (1) that in all cases, the physicians' contracts with North Ridge increased their salaries and benefits over previous levels, in some cases by more than 50%; (2) that all of the salaries reviewed exceeded Medical Group Management Association mean compensation for Internal Medicine (a commonly used industry benchmark); (3) that Tenet's internal analyses showed that each doctor's practice was losing money; and (4) that in most of the files he reviewed, North Ridge considered the amount of the doctor's lab work "as a basis for determining the level of compensation for the physician."

85. After receiving the Bennett Memo, Mr. Heinemann forwarded it to Defendant Sulzbach.

86. Soon after she received the Bennett Memo, Defendant Sulzbach met with Mr. Bennett and one of Tenet's outside attorneys, Thomas E. Holliday, to discuss Mr. Bennett's concerns.

87. On May 27, 1997, acting at the direction of Defendant Sulzbach, the law firm of McDermott, Will & Emery produced a report analyzing the issues that had been raised in the Bennett Memo. As discussed above, the draft report explained in detail why a number of physician employment contracts at North Ridge, including all of the contracts at issue in this case, violated the Stark Statute.

88. On June 23, 1997, acting at the direction of Defendant Sulzbach, McDermott, Will & Emery produced a slightly modified version of its May 27, 1997 report. As discussed above, this report reached the same conclusions as the May report with respect to the twelve contracts at issue in this case.

89. On or about June 27, 1997, four days after the second McDermott report was issued, Tenet submitted its annual Compliance Report to HHS. The report included a sworn declaration from Ms. Sulzbach, acting in her capacity as Tenet's Corporate Integrity Program Director, in which she stated that the Compliance Report was prepared under her direction, and that:

> The Company has reviewed its records and practices during the preceding twelve (12) months and, to the best of my knowledge and belief, is in material compliance with the terms of the Corporate Integrity Agreement, as well as 42 U.S.C. Sections 1320(a) -7(a) and 1320(a)-7(b), and other federal program legal requirements, and has retained all documentation pertinent to this determination.

90. On July 31, 1997, Defendant Sulzbach wrote a memo to Mr. Heinemann entitled "Compliance Reviews of Tenet Physician Services by McDermott, Will & Emery." The memorandum stated in part:

> As you are aware, pursuant to our compliance program and Corporate Integrity Agreement, we requested McDermott, Will & Emery to conduct a privileged audit of several physician group practices in southern Florida. Under my direction, we ask that you implement the corrective action identified by McDermott, Will & Emery. Please provide me a written report on the status of the corrective action within 30 days. Failure to comply with the corrective action may result

in our having to report certain issues to the Department of Health and Human Services pursuant to the terms of the Corporate Integrity Agreement.

It is my understanding that Debbie McCormick and Myla Reizen will be involved in the corrective action. Please have them work through either Cori MacDonneil or myself.

91. Tenet did not stop violating the Stark Statute within 30 days of the issuance of Defendant Sulzbach's July 31, 1997 memorandum. On the contrary, it continued (a) to employ Drs. Shook and Erdman under their existing contracts, and to bill Medicare illegally for referrals from them, until approximately August 4, 1999; (b) to employ Drs. Mellin and Schwartz under their existing contracts, and to bill Medicare illegally for referrals from them, until approximately February 2, 1999; (c) to employ Drs. Gozansky, Dolchin, and Copen under their existing contracts, and to bill Medicare illegally for referrals from them, until approximately January 28, 1999; (d) to employ Dr. Yesner under his existing contract, and to bill Medicare illegally for referrals from him, until approximately November 8, 1998; (e) to employ Drs. Coleman and Perer under their existing contracts, and to bill Medicare illegally for referrals from them, until approximately March 1, 1998; and (f) to employ Drs. Shapiro and Angelillo under their existing contracts, and to bill Medicare illegally for referrals from them, until approximately January 1, 1998.

92. On or about June 26, 1998, Tenet submitted its 1998 annual Compliance Report to HHS. Again, the report included a sworn declaration from Defendant Sulzbach stating that the Compliance Report had been prepared under her direction, and certifying that to the best of her knowledge and belief, Tenet was in material compliance with all federal program legal requirements. As noted in the preceding paragraph, at least eight of the twelve physician employment contracts at issue in this case remained in effect on that date, and Tenet was continuing to bill Medicare for referrals from those physicians.

93. At no time did Defendant Sulzbach notify the Government of the existence of potential Stark Statute violations at North Ridge, nor did she cause anyone else to notify the Government of these issues. She did not notify the Government or cause the Government to be notified of the existence of the Bennett Memo, the McDermott reports, or any internal investigation of potential Stark problems at North Ridge.

IX. THE BARBERA *QUI TAM* LITIGATION

94. On May 13, 1997, a former Tenet employee named Sal Barbera filed a *qui tam* lawsuit under seal ("the Barbera qui tam") alleging that Tenet had violated the False Claims Act by, among other things, knowingly violating the Stark Statute by billing Medicare for referrals from physicians at North Ridge with whom the company had an improper financial relationship.

95. During the course of the Barbera *qui tam* litigation, Tenet consistently denied that any of the physician employment arrangements at issue violated the Stark Statute. For example, in a brief filed on August 11, 2003, Tenet stated that at trial, it would "show factually that the contracts did not exceed fair market value, were commercially reasonable and did not take into account referrals in setting compensation." Similarly, the Defendants' Trial Memorandum, which was filed on December 8, 2003, stated, "[T]he physician arrangements satisfy the bona fide employment exception to the Stark Law because the compensation was consistent with fair market value, did not take into account the value or volume of referrals, and was commercially reasonable."

96. During the Barbera *qui tam* litigation, Tenet also denied that its employees had reason to believe that the compensation of the physicians at issue exceeded fair market value. For example, in its Trial Memorandum, Tenet argued that the issue of fair market value "largely boil[ed] down to" a disagreement between the parties' experts, and stated, "Even allowing for the possibility of a Stark Law violation, Plaintiffs cannot legitimately maintain False Claims Act claims based on their own expert's hindsight approach to determining fair market value."

97. Tenet refused to produce roughly 17,000 documents that were responsive to document requests that the Government made during its investigation and litigation of the Barbera *qui tam*. In response to a subpoena issued by the Government while the case was under seal, Tenet provided the Government with a privilege log that was over 1,000 pages long, which identified almost 7,000 responsive documents that Tenet was withholding as privileged. Later, in response to document requests issued by the Government during the course of the litigation, Tenet produced another privilege log that was over 1,300 pages long, and identified over 10,000 documents that Tenet was refusing to produce. Upon information and belief, Defendant Sulzbach participated in the decision to withhold these documents from the Government.

98. The Barbera *qui tam* litigation was settled just before the case was scheduled to go to trial. Pursuant to the final settlement, which was executed in March 2004, Tenet paid the Government $22.5 million. At the time, this was the largest Stark settlement by a single hospital in the history of the Stark Statute. The settlement was not limited to the twelve physician relationships at issue in this case. The settlement did not release any claims the Government might have against any individuals.

X. TENET'S PRODUCTION OF DOCUMENTS IN 2006

99. During the Barbera *qui tam* litigation, the Government filed a motion to obtain the documents identified on Tenet's privilege logs. That motion was pending when the case settled in 2004, and the Government did not obtain access to those documents at the time.

100. In 2006, Tenet entered into a settlement with the Government to settle a variety of claims that Tenet had defrauded and overcharged the Medicare program. Among other things, Tenet agreed to pay the Government $920 million, and to produce to the Government a number of documents that had previously been withheld as privileged, including a small number of documents related to the Barbera *qui tam* case. Pursuant to that settlement, in or about July 2006, Tenet produced to the Government copies of the May 1997 McDermott Report, the June 1997 McDermott Report, and Defendant Sulzbach's July 31, 1997 memorandum. Prior to that time, the Government had no knowledge of the contents of the McDermott Reports, and no knowledge of what advice Defendant Sulzbach had received from McDermott regarding the Stark problems at North Ridge.

XI. DAMAGES

101. The United States has identified over 70,000 individual payments that Tenet obtained from the United States unlawfully, and for which the United States contends that Defendant Sulzbach

is legally responsible. These payments totaled roughly $18 million. In order to protect patient privacy and to comply with Federal Rule of Civil Procedure 8, the Government will provide a detailed list of these payments to the Defendant promptly upon entry of an appropriate protective order by the Court. The Government will confer with defense counsel concerning the language of a protective order promptly after service of this Complaint.

102. The United States was injured and suffered damages because of Defendant Sulzbach's submission of false certifications, her failure to stop Tenet from violating the Stark Statute, and her failure to report Tenet's violations to the Government, because (1) her actions permitted Tenet to receive payments that it was not entitled to receive, and (2) her actions obstructed the Government's efforts to discover and recover past improper payments.

103. Under the False Claims Act, the United States is entitled to recover treble damages and penalties of $5-10,000 per violation. When, as here, the Government has received partial payment for its claims under the False Claims Act, the defendant is entitled to an offset for the amounts previously collected on the claims at issue, but the offset is deducted only after damages have been trebled.

FIRST CAUSE OF ACTION

(False Claims Act: Presentation of False Claims)
(31 U.S.C. § 3729(a)(1))

104. Plaintiff repeats and realleges ¶¶ 1 through 103 as if fully set forth herein.

105. The Defendant knowingly presented or caused to be presented false or fraudulent claims for payment or approval to the United States.

106. By virtue of the false or fraudulent claims made or caused to be made by the Defendant, the United States suffered damages and therefore is entitled to statutory damages under the False Claims Act, to be determined at trial, plus civil penalties.

SECOND CAUSE OF ACTION

(False Claims Act: Making or Using False Record or Statement to Cause False Claim to be Presented)
(31 U.S.C. § 3729(a)(2))

107. Plaintiff repeats and realleges ¶¶ 1 through 103 as if fully set forth herein.

108. The Defendant knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims paid or approved by the United States.

109. By virtue of the false records or false statements made by the Defendant in support of false or fraudulent claims, the United States suffered damages and therefore is entitled to

statutory damages under the False Claims Act, to be determined at trial, plus civil penalties.

THIRD CAUSE OF ACTION

(False Claims Act; Making or Using False Record or Statement to Avoid an Obligation to Refund) (31 U.S.C. § 3729(a)(7))

110. Plaintiff repeats and realleges ¶¶ 1 through 103 as if fully set forth herein.

111. The Defendant knowingly made, used or caused to be made or used false records or statements to conceal, avoid or decrease an obligation to pay or transmit money or property to the United States.

112. By virtue of the false records or false statements made by the defendants to avoid an obligation, the United States suffered damages and therefore is entitled to statutory damages under the False Claims Act, to be determined at trial, plus civil penalties.

PRAYER FOR RELIEF

WHEREFORE, the United States demands and prays that judgment be entered in its favor against the Defendant, under the False Claims Act, for the amount of the United States' damages, trebled as required by law, and such civil penalties as are required by law, together with all such further relief as may be just and proper.

Respectfully submitted,

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